DELLIGATTI & MILEWSKI
ORTHODONTICS
MAKING BEAUTIFUL SMILES SINCE 1979

Orthodontic Specialists for Children and Adolescents

To The Parents/Guardians of _____,

Thank you for choosing our office for your orthodontic treatment. Your appointment for an orthodontic consultation is scheduled for

_____at _____.

Enclosed you will find an Orthodontic Acquaintance Card and several forms. Please complete all forms and bring them along with your insurance card(s) and insurance information to your consultation appointment.

Please note that a parent or legal guardian for the initial consultation MUST accompany any child under the age of 18.

If you have any questions, please feel free to call our office at 215-283-2440.

Sincerely,

DelliGatti and Milewski Orthodontic Group

WELCOME TO DELLIGATTI AND MILEWSKI ORTHODONTICS

Please fill out our survey so that we may better serve your orthodontic needs.

Patient Name: _____ Date: _____

Account # _____ Insurance Co. _____

How did you hear about us?

- ☐ Pediatric Dental Associates Referral
- ☐ Friend - If so, whom may we thank? _____
- ☐ General Dentist/Pediatrician - Name of Dentist/Doctor _____
- ☐ Internet/Website - www.teethforkids.com
- ☐ Billboard
- ☐ Newspaper
- ☐ Yellow Pages
- ☐ Insurance company - If so, which company? _____
- ☐ Other: _____

Have you seen our ads at any of the following locations?

- ☐ Bus shelter
- ☐ Billboard
- ☐ Newspaper
- ☐ Train Station
- ☐ Back of a bus
- ☐ Church Bulletin

If yes, did this influence your decision to visit our office?

- ☐ Yes
- ☐ No

Have you ever seen our website?

- ☐ Yes
- ☐ No

If yes, how did you get our website address?

- ☐ Billboard
- ☐ Yellow pages
- ☐ Newspaper ad
- ☐
- ☐ Insurance company
- ☐ Other _____

Did you have difficulty finding our office?

- ☐ Yes
- ☐ No

What helped you to make the decision to use our services? Please check your top three:

- ☐ Insurance
- ☐ Reputation of Doctors
- ☐ Location
- ☐ Doctor's Referral
- ☐ Convenient Hours
- ☐ Recommendation of Friend

Thank you for taking the time to answer these questions. We hope that this will ultimately lead to a better understanding of our patient's needs. During the course of your child's treatment, please feel free to provide us with any suggestions you may have. Should you have any questions, please feel free to ask at any time.

OFFICE POLICY REGARDING INSURANCE PAYMENTS

- We will arrange your payment plan according to the insurance plan(s) you have at the onset of treatment.
- If your insurance denies payment for any office procedures performed, you will be responsible for the balance in full.
- If your insurance carrier follows a fee schedule and your coverage is terminated before treatment has been completed, we reserve the right to adjust the fee according to our customary office fee schedule. Any unpaid balance will be due before the braces are removed.
- If you obtain another insurance plan, it is your responsibility to contact the office with your new information. Any insurance change will be submitted as a courtesy to you. Many insurance plans **DO NOT** cover treatment "in progress". The amount still due from your previous carrier will then become your immediate responsibility. Payment cannot be interrupted.
- If your insurance coverage is terminated and you do not have a new plan, any remaining insurance balance becomes your immediate responsibility.

PLEASE SIGN TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION, THANK YOU.

Signature Parent/Legal Guardian: _____

Patient: _____ Date: _____

ORTHODONTIC FINANCIAL INFORMATION

Patient Name _____ Social Security # _____

PARENT/LEGAL GUARDIAN

Mother's Name _____ Mother's DOB _____

Mother's Address: _____

Mother's Social Security # _____ Mother's Cellphone # _____

Father's Name _____ Father's DOB _____

Father's Address (if different from above) _____

Father's Social Security # _____ Father's Cellphone # _____

INSURANCE INFORMATION
(ALL DENTAL INSURANCE CARRIERS FOR PATIENT MUST BE LISTED)

** **Primary Carrier** _____

Name of Insured _____ Payroll # _____

Employer _____

Group # _____

** **Secondary Carrier** _____

Name of Insured _____ Payroll # _____

Employer _____

Group # _____

PARENT/LEGAL GUARDIAN RESPONSIBLE FOR ORTHODONTIC ACCOUNT

Print Name: _____ Relationship to Patient: _____

_____ Date: _____
(Signature of Parent/Guardian responsible for orthodontic account)

Email address for responsible party: _____

ORTHODONTIC ACQUAINTANCE CARD

DATE OF BIRTH _____

PATIENT'S NAME _____ INTIAL ____ AGE ____ SEX ___

STREET ADDRESS _____ TELEPHONE _____

CITY _____ STATE _____ ZIP _____

SCHOOL _____ GRADE _____ REFERRED BY _____

PATIENT'S DENTIST _____ PHYSICIAN _____

FATHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUS. TELEPHONE _____

ADDRESS IF DIFFERENT FROM PATIENT _____

_____

MOTHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUS. TELEPHONE _____

ADDRESS IF DIFFERENT FROM PATIENT _____

NAMES AND AGES OF OTHER CHILDREN IN FAMILY _____

_____

PATIENT MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? Yes ☐ No ☐

If no, explain: _____

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? Yes ☐ No ☐

If yes, explain: _____

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS?

Yes ☐ No ☐

PLEASE LIST _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- ☐ AIDS/ARC/HIV+
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ BLOOD PRESSURE (HIGH/LOW)
- ☐ DIABETES, YEAR DIAGNOSED___
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING SPELLS OR SEIZURES
- ☐ HAY FEVER
- ☐ HEAD INJURIES
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS, JAUNDICE, LIVER DISEASE
- ☐ KIDNEY DISEASE
- ☐ MENTAL ILLNESS
- ☐ MITRAL VALVE PROLAPSE
- ☐ NERVE DISORDERS
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY TREATMENT
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM ARTHRITIS
- ☐ SINUS TROUBLES
- ☐ STROKE
- ☐ STOMACH ULCERS
- ☐ TUBERCULOSIS
- ☐ TUMORS OR GROWTHS
- ☐ VENEREAL DISEASE

IS THE PATIENT SUSCEPTIBLE TO:

- ☐ COLDS
- ☐ SORE THROATS
- ☐ EAR INFECTIONS

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ Yes ☐ No ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS: _____

_____

_____

LIST ANY ALLE RGIES OR DRUG SENSITIVITY: _____

_____

HAS THE PATIENT REACHED PUBERTY?

GIRLS – STARTED MENSTRUAL CYCLE? Yes ☐ No ☐

BOYS – HAS HIS VOICE CHANGED? Yes ☐ No ☐

CURRENT HEIGHT _____ CURRENT WEIGHT _____

DENTAL HISTORY OF PATIENT

HAS THERE BEEN ANY INJURIES TO FACE, MOUTH OR TEETH? Yes ☐ No ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? Yes ☐ No ☐

UNTIL WHAT AGE? _____

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? Yes ☐ No ☐

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? Yes ☐ No ☐

WHILE ASLEEP? Yes ☐ No ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? Yes ☐ No ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? Yes ☐ No ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? Yes ☐ No ☐

LIST ANY MUSICAL INSTRUMENTS PLAYED: _____ Yes ☐ No ☐

DO YOU HAVE OR USE ANY OF THE FOLLOWING?

- ☐ TEETH SENSITIVE TO HEAT, COLD, SWEETS OR PRESSURE
- ☐ BLEEDING GUMS, IF CHECKED HOW LONG? _____
- ☐ FREQUENT BLISTERS ON LIPS OR MOUTH
- ☐ SWELLING OR LUMPS IN MOUTH
- ☐ COMPLICATIONS FROM EXTRACTIONS
- ☐ CLENCHING OR GRINDING
- ☐ BURNING OF TONGUE
- ☐ FINGERNAIL BITING, CHEEK BITING
- ☐ CIGARETTES, SMOKING

- ☐ GUM TREATMENT
- ☐ UNPLEASANT TASTE
- ☐ BAD BREATH
- ☐ INTERDENTAL STIMULATORS
- ☐ BRAND NAME OF MOUTHWASH
- ☐ ORTHODONTIC TREATMENT/APPLIANCES
- ☐ FLUORIDE TREATMENTS
- ☐ DISCLOSING TABLETS
- ☐ CLICKING OF JAW
- ☐ NECK ACHES
- ☐ EAR RINGING
- ☐ PRIOR ORTHODONTICS
- ☐ LOCKING OF JAW
- ☐ BACK ACHES
- ☐ EARACHE
- ☐ PREVIOUS DENTAL SPLINT
- ☐ DIFFICULTY IN CHEWING
- ☐ THERAPY OR NITE GUARD
- ☐ FREQUENT HEADACHES
- ☐ JAW INJURY
- ☐ PREVIOUS TOOTH ADJUSTMENT BY GRINDING
- ☐ WISDOM TEETH REMOVAL

  WHEN _____

REASON FOR CONSULTATION:

_____

_____

Parent's Signature

_____

Date

DelliGatti and Milewski Orthodontic Group

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice effective April 14, 2003. We do reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you may be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records
- Diseases spread person to person
- Drug and/or alcohol abuse
- Medical History
- Treatment in progress
- Any other related facts

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment.
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management.
3. Any personal care facility where you live.
4. Any other doctor providing your care.
5. Family members and other people who are part of your plan for service.
6. State and Federal agencies acting on behalf of programs such as Medicare or Medicaid.
7. Other health care workers to start treatment.

We may contact you via telephone, postcard or other mailings to:

1. Provide appointment reminders.
2. Discuss issues involving payments on your account.

We may use a sign-in sheet for:

1. The purpose of keeping track of patients that are being seen on a daily basis. This sheet is destroyed at the completion of each day.

We may take photographs to:

1. Use for decisions made in dental treatment.
2. Posting within our offices for the purpose of showing the progression of treatment.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment
2. Where significant barriers to communication with you exist and we determine that the consent is clearly inferred from the situation
3. Where we are required by law to provide treatment and we are unable to obtain consent
4. For certain public health activities, such as reporting injuries, death, diseases, etc.
5. Where the use or disclosure is required by law
6. Where we reasonably believe you are a victim of abuse, neglect or domestic violence
7. To coroners, medical examiners and funeral directors.
8. For certain research purposes
9. For Workman's Compensation purposes
10. For specialized government functions, including custodial situations

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules)
2. To a family member, friend or other-person you choose, who may assist in your care or payment for care

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you; however, we are not required to agree to the requested restrictions.
2. Receive confidential communication by giving us another address.
3. Inspect and receive a copy of protected health data by filling out our request form.
4. Receive a list of disclosures made of your protected health data by filling out our request form.
5. Amend protected health data by filing out our request form.
6. Obtain a copy of this notice at any time.

COMPLAINTS

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. The complaint must be filed in writing with us, and must state the specific incident(s) including the date, what happened and details of the incident. For details about filing a complaint with us, contact:

DelliGatti & Milewski Orthodontic Group, PC
% MARILYN SCARTOLI
7 E. Skippack Pike, Suite 105
Ambler, PA 19002
215-283-2440

ACKNOWLEDGEMENT

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I hereby certify that I have received a copy of DelliGatti & Milewski Orthodontic Group, PC notice of Privacy Practices:

_____ _____ / _____ / _____

Printed Name of Recipient Date

_____

Signature of Recipient

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the above referenced individual, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency prevented us from obtaining acknowledgement

_____ Other (Please specify)

_____

_____
